DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185264	A. BUILDING _____ B. WING _____	02/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLESTON HEALTH CARE CENTER	203 BRUCE CHURCH RD BOX 730 DANVILLE, KY 40423

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F 000	INITIAL COMMENTS An abbreviated standard survey (KY15880) was conducted on February 22-23, 2011. The allegation was substantiated. Deficient practice was identified with the highest scope and severity being at "D" level.	F 000	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to provide services to residents in accordance with each resident's written plan of care. Resident #2 and resident #3 had a written plan of care for staff to turn and reposition the residents every two hours. However, observations revealed the residents were not turned or repositioned for four hours on February 22, 2011. The findings include: 1. A review of resident #2's medical record revealed the resident was admitted to the facility on January 3, 2011, with diagnoses of Paranoia, Diabetes, Hypertension, Cerebral Vascular Accident, Delusions, and Psychosocial Stressors. Review of resident #2's admission assessment dated February 3, 2011, revealed the resident required extensive assistance of two staff persons for bed mobility and transfers. The admission assessment revealed the resident was	F 282	**F282** It is the policy of Charleston Health Care Center to ensure residents are provided services in accordance with each resident's written plan of care. **Resident #2:** On 2/24/11, Charleston Health Care Center began turning and/or repositioning the resident every 2 hours pursuant to the resident's written plan of care. In addition, on 2/24/11, shift nurses began monitoring compliance with the patient repositioning schedules. As such, Charleston came into full compliance on 2/24/11. Specifically, the resident's written plan of care was reviewed and it was determined that the resident requires extensive assistance of two staff persons for bed mobility and transfers. Due to the resident's limited physical mobility, the resident is at risk for skin breakdown. As an intervention, Charleston Healthcare will turn and/or reposition the resident every 2 hours. In addition, in order to ensure future compliance, Charleston will implement policies, procedures, and actions that exceed the necessary requirements for compliance. Specifically, Charleston has updated its Decubitus Prevention and Care policy and developed a new Turn Reposition Record Form on 3/11/11. This updated policy and new form will be given to all clinical staff on 3/16/11. Further, an in-service will be conducted on 3/16/11 for all CNA's, KMA's, LPN's, and RN's regarding the new repositioning log sheet requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Asst. Admin. — (X6) DATE: 3-14-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 at risk for the development of pressure ulcers but did not have a pressure ulcer at this time. A review of resident #2's plan of care dated January 18, 2011, revealed a problem area addressing the resident's risk for skin breakdown with an intervention for the resident to be turned and repositioned every two hours. Observations conducted on February 22, 2011, at 12:40 p.m., 2:10 p.m., 4:35 p.m., and 5:00 p.m., revealed resident #2 in bed lying on the resident's back. The observations revealed the resident was not turned and repositioned from 12:40 p.m. until 5:00 p.m. A skin observation conducted on February 22, 2011, at 5:00 p.m., revealed no skin breakdown noted. The skin observation revealed redness to the crease of the resident's buttocks, to which staff applied a barrier cream. 2. A review of resident #3's medical record revealed the resident was admitted to the facility on May 16, 2007, with diagnoses of Diabetes, Hypothyroidism, Hypertension, Psychosis, Hiatal Hernia, Peripheral Neuropathy, Alzheimer's, and Depression. Review of resident #3's significant change assessment dated February 7, 2011, revealed the resident required extensive assistance of two staff persons for bed mobility and transfers. The assessment revealed the resident was at risk for the development of pressure ulcers but did not have a pressure ulcer at this time. A review of resident #3's plan of care dated February 17, 2011, revealed a problem area addressing the resident's risk for skin breakdown	F 282	On 3/16/2011, clinical staff will begin using the newly developed Turn Reposition Record Form. Each turn and/or repositioning of the resident will be logged on this form and initialed by the staff person completing the turn. Further, the shift nurse will monitor compliance by reviewing and signing these forms at the end of each shift to indicate the repositioning and documentation thereof, has been completed. To ensure compliance, the DON will conduct a random audit sampling with these new procedural requirements on a weekly basis. **Resident #3:** On 3/24/11, Charleston Health Care Center began turning and/or repositioning the resident every 2 hours pursuant to the resident's written plan of care. In addition, on 2/24/11, shift nurses began monitoring compliance with the patient repositioning schedules in use. Thus, Charleston came into full compliance on 2/24/11. Specifically, the resident's written plan of care was reviewed and it was determined that the resident requires extensive assistance of two staff persons for bed mobility and transfers. Due to the resident's limited physical mobility, the resident is at risk for skin breakdown. As an intervention, Charleston Healthcare will turn and/or reposition the resident every 2 hours and has in place a schedule to do so. In addition, to further assure future compliance, Charleston will implement policies, procedures, and actions that exceed the necessary requirements for compliance. Specifically, Charleston has updated its Decubitus Prevention and Care policy and developed a Turn Reposition Record Form on 3/11/11. This updated policy and newly developed form will be given to all clinical staff on 3/16/11. Further, an in-service will be conducted on 3/16/11 for all CNA's, KMA's, LPN's, and RN's regarding the new repositioning log sheet requirements.	

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F 282	Continued From page 2 with an intervention for the resident to be turned and repositioned every two hours. Observations conducted on February 22, 2011, at 12:40 p.m., 2:10 p.m., and 4:35 p.m., revealed resident #3 in bed lying on the resident's back. The observations revealed the resident was not turned and repositioned from 12:40 p.m. until 4:35 p.m. A skin observation conducted on February 22, 2011, at 5:10 p.m., revealed no skin breakdown or redness noted. Interviews conducted on February 22, 2011, at 2:25 p.m. with LPN #1, at 4:05 p.m. with SRNA #1, at 4:20 p.m. with LPN #2, and at 6:06 p.m. with SRNA #2 revealed most residents while in bed were required to be turned and repositioned every two hours to prevent skin breakdown. Interview with LPN #1 and LPN #2 revealed the LPNs monitored to ensure staff was performing turns every two hours by checking the Scheduled Turn sheets in the residents' rooms. However, there were no Scheduled Turn sheets in resident #2 and resident #3's rooms. An interview conducted on February 22, 2011, at 5:45 p.m., with the DON revealed the DON monitored to ensure residents were being turned and repositioned every two hours by making rounds on the halls. The interview revealed the DON also checked the Scheduled Turn sheets to ensure staff was turning and repositioning residents every two hours. Review of the facility's Decubitus Prevention and Care policy dated August 7, 2003, revealed prevention of pressure sores was always easier	F 282	On 3/16/2011, clinical staff will be required to use the new Turn Reposition Record Form. Each turn and/or repositioning of a resident will be logged on this form and initialed by the staff person completing the turn. Further, the shift nurse will monitor compliance by reviewing and signing these forms at the end of each shift making sure that the repositioning and documentation of such, has been completed. Further, The DON will also conduct a random sampling audit to ensure compliance with these new requirements on a weekly basis. **All Other Residents:** The Care Planning team will assess and review all residents for the risk of skin breakdown on admission, readmission, change of condition as well as on a quarterly basis. If it is determined that the resident is at risk for skin breakdown, they will also be placed on a turning/repositioning schedule that will be documented on the new Turn Reposition Record Form. Shift nurses will monitor compliance with the patient repositioning log and will sign off at the end of each shift that the repositioning and documentation thereof, has been completed. The DON will also conduct a random sampling audit on a weekly basis to ensure compliance with these new procedural requirements. As new residents are admitted and determined to be at risk for skin breakdown due to decreased mobility, they will be placed on a turning/repositioning schedule that will be documented on the new Turn Reposition Record Form. In addition, on 3/11/11, Charleston updated its Decubitus Prevention and Care policy previously dated August 7, 2003. 3/17/11	

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F 282	Continued From page 3 than curing a pressure sore. According to the policy, the most important aspects of prevention included: 1) Frequent changes in body position (every two hours by resident or staff), 2) Good skin care (keep resident and bedding clean/dry and adequate back care), and 3) Medications (Zinc Oxide, Balsam of Peru).	F 282		